Minnesota Response to
CMS Questions re. Minnesota's Family Planning §1115 Waiver Request

1. P. 7. How many persons are currently served by the Title X and Family Planning Special Projects (FPSP) programs. How many persons currently remain in need of services even with these programs in place?

For calendar year 2001, approximately 5,000 people were served through Title X grants in St. Paul and Minneapolis and 38,000 were served through Title X grants administered by the Minnesota Department of Health. About 42,000 Minnesotans received services from Planned Parenthood of South Dakota and Minnesota, via FSPS grants.

2. P. 9. You state that in July 2001 the Minnesota legislature enacted law creating the family planning demonstration project. Please provide additional details. Is this a State project that is currently in place, or is this approval for the State to purse a Federal Family Planning 1115 demonstration authority?

Minnesota Statutes 256B.78 Medical assistance demonstration project for family planning services, provides that:

> (a) The commissioner of human services shall establish a medical assistance demonstration project to determine whether improved access to coverage of prepregnancy family planning services reduces medical assistance and MFIP costs, and
>
> (b) This section is effective upon federal approval of the demonstration project.

Thus, this is a new project, not a refinancing of a current state-only project with federal dollars.

3. P. 13. You state that "insurance barriers and asset limits may apply to some populations such as adults." Please clarify what limits, and for which populations, you are considering.

The statement on page 13 describes the State's current Medical Assistance, General Assistance Medical Care, and MinnesotaCare programs. Some populations enrolled in these programs have insurance barriers and asset limits. However, the State is not considering either for the family planning project.

4. Under Eligible Populations, the State projects serving approximately 30,000 enrollees when fully operational. Please reconcile this with the projections in the budget neutrality information.

This is an error. The State expects that up to 223,000 people will be enrolled in this program in the final year of the demonstration. Approximately 62,000 of these enrollees are expected to access services that year.

5. P. 14. Please describe your family planning service delivery network and provide assurances that the number of available providers is sufficient to meet the increased demand for services that this waiver will generate. Please provide us with any State-conducted analyses of the adequacy of this provider capacity that you may have conducted.

6. If a shortage of providers occurs, please describe the methods the State will use to recruit family planning providers.

Minnesota enjoys broad physician participation in its public health care programs. Under the family planning demonstration, virtually every primary care physician in the state will be a participating provider. A shortage of providers under the family planning project would be but one indication of far more serious problems.

7. Under covered services what does "diagnosis and treatment of infertility" services include? What does "genetic counseling" services include?

As defined in the Chicago Regional State Letter NO: 37-93 and the updated 1997 version, Minnesota covers the following **infertility services** when submitted in conjunction with primary or secondary diagnosis codes in the V25, V26, 606 or 628 series:

54900 Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral
54901 Epididymovasostomy, anastomosis of epididymis to vas deferens; bilateral
55870 Electroejaculation
58672 Laparoscopy, surgical; with lysis of adhesions with fimbrioplasty
58345 Transcervical introduction of fallopiean tube catheter for diagnosis and /or re-establishing potency , with or without hysterosalpingography
58350 Chromotubation of oviduct, including materials
58752 Tubouterine implantation
58760 Fimbrioplasty
58825 Transposition, ovary(s) and
58920 Wedge resection or bisection of ovary, unilateral or bilateral.

In addition, laboratory screening tests in the CPT 80000-89399 range needed to diagnose infertility are covered when submitted with the V25, V26, 606 or 628 diagnosis codes. Services for artificial insemination, in-vitro fertilization, fertility drugs and reversal of voluntary sterilization are excluded from coverage.

Genetic counseling, testing and diagnostic services are covered for MA eligible people seeking family planning services, excluding pregnant women, when submitted in conjunction with primary or secondary diagnosis codes in the V25, V26, 606 or 628 series:

99201 -99499 Evaluation and Management codes as appropriate for visits and consultations

In addition, laboratory screening tests in the CPT 80000-89399 range used for cytogenetic studies are covered when submitted with the V25, V26, 606 or 628 diagnosis codes.

8. How are services different under the family planning waiver from those currently covered for MA, GAMC, and MN Care?

They are the same. All of the services that will be covered under the family planning project are covered services under MA, GAMC and MinnesotaCare. Treatment for STDs is not a *family planning* service under MA, GAMC, and MinnesotaCare, but is a covered service nonetheless.

9. The State proposes that "Other family planning program enrollees will have the option of receiving or refusing an [MA] identification card." Will there be any affect on access to services and/or providers depending on an enrollee's choice of whether to receive a card? What is the reason for giving enrollees that choice? Please clarify. Former MHCP enrollees will already have an ID card.

Individuals who apply at a family planning provider will have a choice whether they want to receive a card. Some individuals may not want to receive a card because it would be mailed to them at a later date. Teens might not want anything mailed to them at home, for instance. They could opt for a card to be mailed to an alternative address, or they could opt not to get a card. This will not affect access to services because eligibility could be verified with a social security number or their ID number by any provider via the electronic verification system (EVS). Whether they return to the clinic that enrolled them for future services, or they go to another clinic, the EVS will be used by the provider to verify their eligibility. The card is useful in that it shows their ID number, but providers always verify via the EVS before they give services. Individuals who are granted presumptive eligibility through a provider will get a print out that has their ID number, which they can keep for future reference if they decide to suppress the ID card.

10. P. 15. Please describe the process you will use to ensure that enrollees exiting Minnesota Health Care Programs due to death or permanently moving out of the State will be excluded from coverage and how former enrollees will have the opportunity to decline family planning coverage.

Currently, there are specific codes workers enter on our MMIS system for MinnesotaCare enrollees who are cancelled due to death or moving out of the state. We will expand the use of these codes to MA and GAMC enrollees and will interface the indicators for death and moving out of the state currently in MAXIS to trigger the codes in MMIS. When exiting enrollees are automatically converted to the family planning project, the enrollees coded for death or leaving the state will not be converted.

11. Please provide assurances that the State will screen potential family planning program participants for eligibility in other Minnesota Health Care Programs, and enroll them in programs that they may be found eligible for.

Individuals who enroll in the family planning project through a provider will be given information about the other MHCP. The State does not plan to collect the amount of information that would be needed to screen these individuals for MHCP (Household income, assets, presence of disability, immigration status, insurance status). This would be far too intrusive and would deter potential applicants. The State will include a question on the application inquiring whether the applicant would like to apply for other MHCP, and will follow up by sending out an application packet to interested applicants. Individuals who are automatically eligible for family planning after exiting another program will have been redetermined prior to their exit and found to be ineligible.

13. Please explain the rationale for not collecting the individual's (as opposed to family) income information for applicants under age 21.

The State believes that requiring teens to disclose income information will deter them from enrolling in the program. In addition, since the income guideline is 275 percent of FPG, it is unlikely that many teens will have income exceeding the limits.

14. After the providers have determined temporary eligibility and forwarded applications to the State, how long does the process to determine ongoing eligibility take? What happens if the enrollees are determined not to be eligible for the program?

Applications for family planning will be processed within 30 days. The presumptive eligibility period will be 30 days. If an individual who is presumed eligible is found to be ineligible, the individual's family planning coverage is closed at the end of the presumptive period.

15. Based on prior experience are there any estimates on the number of cases where this might be a problem? Is there a system in place for ensuring continued care for the recipient?

The State does not anticipate that this will be a problem as the eligibility criteria for presumptive and ongoing family planning eligibility will be very simple and straight forward. Since income is not a factor for children under 21, we expect very few teens who are presumed eligible will be denied ongoing family planning coverage. Presumptive eligibility will be available only through a family planning provider. An applicant who is presumed eligible by a provider and later found to be ineligible will have access to continued care through the resources of that provider – the way they pay for services now - Title X

16. Please clarify MN's policy on not claiming FFP for services provided during the PE period.

The State does intend to claim FFP for services provided during the presumptive eligibility period, as we do for the Breast and Cervical Cancer program.

17. As stated in your request, the rate of unintended pregnancies is highest among low- income women of color. Please define women of color and explain how outreach efforts will target this population to receive the services offered in this waiver?

In the State's waiver request the term "women of color" has the generally-understood meaning "women of other than Caucasian race or non-Hispanic ethnicity." As people of color represent a disproportionately large part of MHCP enrollment, this population will be targeted via automatic enrollment in the family planning project upon exiting other health care programs.

18. The proposal says (P.7) that the State currently "reaches only 48 percent of the women in need of subsidized services. How is the outreach plan designed to increase the percentage of the target population enrolled in this family planning program?

As is explained on Page 7, a key reason that only 48 percent of women in need of subsidized family planning services is that funding has been inadequate. The state's current family planning service delivery system is increasingly strained as it strives to serve teenagers and non-English speakers, two groups that require special services if they are to be able to understand and implement family planning instruction. In addition, limited service delivery sites are especially problematic in rural parts of the state.

The Minnesota Family Planning Project will address these needs both by increasing funding to the system as a whole, and by increasing the number of sites where enrollees may access family planning services to include virtually every primary care provider in the state.

19. P. 16. Please see the attached document that includes CMS' requirements for primary care services and respond as appropriate.

All enrollees of the Family Planning Program will receive information about Minnesota's other health care programs, which cover primary care services. Enrollees who participate in the Family Planning Program after exiting MA, GAMC or MinnesotaCare will receive information about how to apply for other programs on their cancellation notices. Notices for Medical Assistance and General Assistance Medical Care enrollees include information about applying for MinnesotaCare. In addition, MA and GAMC enrollees are routinely referred for MinnesotaCare determinations if they become ineligible due to income or assets. Cancellation notices for MinnesotaCare enrollees include information about applying for MA, GAMC, and Minnesota Comprehensive Health Association, the state's high-risk pool.

Enrollees who apply for the Family Planning Program via a medical provider will receive a Minnesota Health Care Programs Brochure upon application. This brochure contains a description of each Minnesota public health program, a list of covered services, basic eligibility criteria and contact phone numbers. Brochure DHS 3182 can be found online at http://edocs.dhs.state.mn.us/default.asp by searching "3182."

In addition, the State has consulted with the Minnesota Primary Care Association. A letter from the association to Mary Kennedy, the state Medicaid Director, expressing the association's understanding and support of this project, is attached.

20. P. 19. Please provide a more detailed description of the roles of each of the State health organizations in implementation of the waiver. Which organization will have primary responsibility for implementation?

The Minnesota Department of Human Services will have primary responsibility for implementation of this program, and continuing responsibility for day-to-day operation of the program, including processing of applications and enrollment functions, and provider reimbursement.

The Minnesota Department of Health has extensive knowledge and experience of FPSP grantees, which will be utilized in educating providers about the program and the presumptive eligibility process. MDH will participate in developing the enrollment process for patients. In addition, MDH has developed several brochures and booklets specifically for teens and adolescents around issues of peer pressure, relationships, etc. This expertise will be used in developing outreach materials, brochures and the application.

21. P. 23. The State should rework their budget neutrality information using the attached spreadsheets for Federal and total spending. Please provide a detailed narrative description of this table, including how the State calculated averted births, trend rates used and how they were determined (source), how costs are determined, how birth data is collected, etc. Please provide three years of historical data for those elements that are available (i.e. costs, trends, births.) Please explain "other female" enrollees.

The State is working with CMS staff to develop appropriate budget neutrality information. This data will be separately submitted.

22. P. 30. Please provide a more detailed description of the project evaluation study including how the State will determine whether this waiver is meeting its goal of reducing the number of unintended pregnancies, who will conduct the study, timeline, costs associated with the study, etc.

The Project Evaluation Study will be conducted by The Performance Measurement and Quality Improvement Division and the Reports and Forecasts Division of DHS along with the Center for Health Statistics and the Family Health Division at MDH. Researchers at DHS will track program enrollment and utilization using data from the data warehouse, which contains claims and encounter data on services received as well as enrollment data and demographic information. This data will be analyzed in conjunction with trends in vital statistics information and Minnesota's (Pregnancy Risk Assessment Monitoring System) PRAMS data gathered by the Minnesota Department of Health. The two agencies have an interagency agreement used to share and match data between the agencies' data bases. The birth certificate data, PRAMS data, and Medicaid eligibility and claims data currently shared between our agencies can also be used for this evaluation.

Using the information from these two agencies, Minnesota will determine whether the waiver is meeting the goal of reducing the number of unintended pregnancies through several measures:

Rate of Unintended Pregnancies

MDH received funding last year to gather PRAMS data for Minnesota. Data collection began in August 2002 for births beginning in May of the same year. The PRAMS survey includes a question about whether or not a pregnancy was intended. At the beginning of project year one DHS will establish a base-line measure of the rate of unintended pregnancies among Medicaid enrollees as well as the statewide population. These two rates will be monitored yearly thereafter. Both measures will include regression analysis in order to control for any changes in the population size, age, race, program type, marital status and income. PRAMS data will be used to establish a baseline rate and re-measured during implementation to monitor the waiver's impact.

· **Rate of unintended pregnancies for Medicaid population, by year**

Numerator: no response to PRAMS question about whether pregnancy was intended
Denominator: PRAMS survey respondents enrolled in Medicaid

· **Rate of unintended pregnancies for general population, by year**

Numerator: no response to PRAMS question about whether pregnancy was intended
Denominator: PRAMS survey respondents

PRAMS data on unintended pregnancies will also be used to establish a rate of unintended teen pregnancies using the same method described above. In addition, assuming that most teen pregnancies are unintended, we expect the teen birth rate in

the Medicaid program to decrease as a result of waiver implementation. DHS will establish a baseline Medicaid teen birth rate and measure the rate during waiver implementation to monitor change.

· **Teen Birth Rate in the Medicaid Program**

Numerator: births to teens
Denominator: teens enrolled in Medicaid

Fertility Rates

Because current data for Minnesota indicates that 43% of all pregnancies are unintended, a decrease in unintended pregnancies should result in a lower fertility rate. At the beginning of project year one DHS will establish a base-line measure of fertility rates for the past several years, both for enrollees and the statewide population. The statewide fertility rate is measured annually by MDH Center for Health Statistics. A fertility rate for the Medicaid enrollee population will be calculated using the same methodology to determine whether the family planning project has had an impact on the fertility rate among medicaid enrollees. The same data will be gathered each year of the project to monitor change.

· **Statewide fertility rate from Vital Statistics, by year***

Numerator: number of pregnancies (including live births, induced abortions and fetal deaths)
Denominator: per 1,000 women in the population between the ages of 15 - 44 years

* controlling for changes in age, race, marital status and income

· **Medicaid population fertility rate, by year****

Numerator: number of pregnancies
Denominator: per 1,000 women enrolled in Medicaid between the ages of 15 - 44 years

** controlling for changes in average enrollment time, age, race, program type, marital status and income

Rate of Re-enrollment Due to Pregnancy

In order to determine whether making family planning services available to Medicaid enrollees leaving the program reduces the rate of unintended pregnancies, Minnesota will measure the number and time span since previous enrollment for women re-enrolling whose basis of eligibility is pregnancy. If 43 percent of all births in Minnesota are unintended, re-enrollment and the time-span between dis-enrollment and re-enrollment should both go down if family planning services are utilized. At the beginning of project year one, DHS will establish a baseline of these two numbers in the current program. The same data will be gathered each year of the project to monitor change.

· **Rate of re-enrollment of former Medicaid clients based on pregnancy status*****

Measure: The number of pregnant women re-enrolling in Medicaid who dis-enrolled less than two years ago

*** controlling for changes in enrollment, age, race, program type, marital status and income

· **Time span between dis-enrollment and re-enrollment based on pregnancy status for previously enrolled women**

Measure: number of months elapsed since dis-enrollment for pregnant women enrolling in Medicaid who were previously enrolled

Costs of the evaluation involve primarily staffing and some systems programming, with the possibility of a small sub-contract for some of the trending measurement depending on in-house staff availability. DHS has allocated $100,000 in the first year of the project and $125,000 for each of the additional years in order to properly evaluate the project.

23. It appears that the only effect on MN Care families with children will be the 24 months of extended coverage after case closure. Is this correct?

Yes, that is correct.

24. What will the State do with the Title V and Title X funds that will be freed up by this waiver? Will MN provide more services or expand the income eligibility for these services?

A. Specialized family planning providers in Minnesota, for example, those who focus on adolescents or immigrant populations, have been struggling for years to cover the staffing and administrative costs associated with the problems that their patients bring with them – talking with teens and adolescents about peer pressure, relationship issues, school, problems in the home, etc. These problems are often barriers to consistent and correct use of family planning methods. Having effective family planning methods is just one piece of the puzzle. Other issues and difficulties in a young person's life can make it less likely that she will be able to avoid a pregnancy. Providers have told us they spend a significant amount of time building trust and relationships so that teens will feel confident in coming back to the clinic for services later. Family planning for teens and adolescents is time-intensive, with office visits that tend to be twice as long as other medical visits. We expect to provide family planning services to more Minnesotans through this demonstration, and we expect to draw more individuals to the family planning clinics with this demonstration. The family planning providers will need the money that is "freed up" to provide much-needed care beyond simply prescribing a family planning method to both their current and new patients.

B. MA reimbursement rates fall far short of costs. Family planning providers will continue to depend on Title V and X funding to cover their expenses. These funding sources provide a financial base upon which they can plan for the year. FPSP grants provide a financial infrastructure that enables clinics to stay open.

C. Family planning clinics will continue to provide services to patients regardless of their ability to pay or their cooperation with applying for the family planning project. We expect that some individuals will refuse to apply for family planning coverage.

D. Many small or specialty family planning providers do not have the staff, patient accounting system and infrastructure to begin billing the state for reimbursement. These providers will have to build or purchase this capability, train staff, and then implement. The billing process will affect cash flow in clinics as the service must be provided before it can be billed, the bill processed, and the payment received.